Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
University Medical Center at Brackenridge

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-14-3190-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As these services were not subject to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code §19.2015 (Regarding "Utilization Review for Healthcare Provided Under Workers' Compensation Insurance Coverage") This section specifically allows for "Retrospective Review of Medical Necessity," and requires carrier to perform "such retrospective review …under the direction of a physician."

Amount in Dispute: $2,429.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Claimant entered the hospital on 7/1/13, underwent a surgical procedure on 7/2/13, and was discharged on 7/4/13. There is no documentation showing that this procedure was an emergency. Requestor did not, at any time during the Claimant's stay, request preauthorization or even concurrent review. Concurrent review is designed for claimants who are already in the hospital when additional treatment is needed. The medical bill in dispute has been denied for Requestor's lack of requesting preauthorization or concurrent review for a surgical procedure which was not documented as an emergency. No reimbursement should be owed."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2 -4, 2013	Inpatient Hospital Services	$2,429.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 197 – Precertification/authorization/notification absent

Issues

1. Did the requestor support services are payable as submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.600 (p) states in pertinent part (p) "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;" Review of the submitted documentation finds no evidence that the services in dispute were submitted to for preauthorization as required by Division guidelines.
2. 28 Texas Administrative Code §134.600 (c) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care;…" As required prior authorization was not sought to seek approval of the provided healthcare, the Division finds the Carrier is not liable for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 9, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.